MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Integra Specialty Group, P.A. 517 N. Carrier Pkwy., Suite G Grand Prairie, TX 75050	MDR Tracking No.: M5-05-1763-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 27 Hartford Underwriters Ins.	Date of Injury: Employer's Name: Revenue Technology Services Insurance Carrier's No.: 978C 55860

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
4/27/04	**11/1/04**	**99213, 97010, 97012, 97032, 97110, 97140, 97750, 95832, 95833, 95851, 96004, 99080**	**$2,811.00**	**$190.81**

PART III: REQUESTOR'S POSITION SUMMARY

2/23/05: Requestor submitted TWCC-60 to MDR requesting reimbursement for services/treatment rendered.

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent did not respond to MDR request.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- On 3/18/05, the Requestor submitted a request via fax: "Please withdraw only the medical necessity disputes on this patient's case, and review the remaining fee issues." Therefore, all DOS that were denied as medical necessity issues will not be reviewed further in this Finding and Decision.

- The remaining dates of service (DOS) will be reviewed as follows per Rule 134.202. The following CPT codes have been supported with convincing evidence through SOAP notes or reports that treatment / services have been rendered. Reimbursement is reviewed according to Rule 134.202 (c) and Medicare participants shall apply the Medicare program reimbursement methodologies.

  a) DOS 4/27/04: CPT codes 95831 and 95832 were denied with "F" – defined, "The services listed under this procedure code are included in a more comprehensive code which accurately describes the entire procedure(s) performed." CPT codes 95831 and 95833 are considered by Medicare methodology to be components unbundled with the office visit 99213, there for reimbursement can not be recommended.

b) DOS 5/11/04: No EOB's were received for this DOS, and convincing evidence was received to verify the HCFA's were submitted to the Respondent timely in accordance with Rule 133.307(e)(2)(B). Reimbursement recommended as follows:

CPT code: **99213** x 1 = **$68.24**

CPT code's **97140 and 97012** are considered by Medicare to be mutually exclusive to each other. A modifier is allowed but was not mentioned. Therefore only one code may be reimbursed. Reimbursement for CPT code **97140 = $34.13**. 97012 = $0.00.

CPT code **97032** x 1= **$20.20**

CPT code: **97110** x 4 = Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

c) DOS 5/24/04: CPT codes **95851** and **97110** were denied with "F"- defined, "The services listed under
this procedure code are included in a more comprehensive code which accurately describes the entire procedure(s) performed."

CPT code **95851**: According to Medicare methodology, this code is considered to be a component of the office visit, therefore reimbursement can not be recommended.

CPT code **97110:** As stated on DOS 5/11/04, reimbursement can not be recommended.

d) DOS 11/1/04: CPT code **99213** No EOB's were received for this DOS, and convincing evidence was received to verify the HCFA's were submitted to the Respondent timely in accordance with Rule 133.307(e)(2)(B). Reimbursement recommended 99213 x 1 DOS= **$68.24**.

Total due: $190.81

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $190.81. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

	Typed Name	
		6 / 8 / 05
Authorized Signature	Name	Date of Order

PART V: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, PO Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____